

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12345

12379

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>		c. LENGTH OF STAY IN 1b <u>30 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Dolphus</u> Last <u>Adams</u>		4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>19 56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-17-1890</u>
9. AGE (In years last birthday) <u>66 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>	
11. BIRTHPLACE (State or foreign country) <u>Renick, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas C. Adams</u>		14. MOTHER'S MAIDEN NAME <u>No information</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>188-07-4810</u>	
17. INFORMANT <u>Elsworth Adams</u>		Address <u>Rising Sun, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Compound Fracture of skull, Fracture of neck</u> DUE TO <u>and left ankle and partial amputation of</u> Conditions, if any, which gave rise to immediate cause (b) <u>right lower leg, laceration of scalp</u> (c) <u>multiple abrasions over body.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hit by a car crossing road.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7:28</u> m. <u>12-15-56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 1</u>		20f. (City or town) (County) (State) <u>Harrisville Cecil Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. C. Dodson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/18/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham</u>		22d. LOCATION (City, town, or county) (State) <u>Colona Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M. Reed</u>		ADDRESS <u>Rising Sun, Md.</u>	
24a. REC'D BY REGISTRAR <u>Dec-18-56</u>		24b. REGISTRAR'S SIGNATURE <u>DMH Wrighton</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 19 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 only should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12346

12380

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 8yrs7mos29days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 3424 - 13th St., N.W.			
3. NAME OF DECEASED (Type or print) First EMMA Middle C. Last AMMON				4. DATE OF DEATH Month December Day 28 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 11, 1879	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 47 Days 13		IF UNDER 24 HRS. Hours 3 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Alton, Illinois	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW-1		17. INFORMANT Hospital Records, VAH., Perry Point, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential vascular or hypertension DUE TO (c) Arteriosclerosis generalized, severe						INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11 Month 19 Day 19 Year 19 p. m. VA		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 29, 1948 to December 28, 1956 and that death occurred at 7:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE William M. Harris, M.D.				M.D. V.A. Hospital, Perry Point, Md. 12-30-56			
PHYSICIAN'S NAME (Type) WILLIAM M. HARRIS, M.D., Actg. Dir. Professional Services, VAH, Perry Point,							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12-30-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Md. Ft. Myer, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE James E. Dougherty				ADDRESS Harold E. Dougherty, Md.		24a. REC'D BY REGISTRAR DATE 12-31-56	
				24b. REGISTRAR'S SIGNATURE James E. Dougherty			

BUREAU V.S.
JAN 3 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12347

12381

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
c. LENGTH OF STAY IN TB 24yrs. 5mos. 4da.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 3005 Eastern Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANK Middle ANTONIAK Last ANTONIAK		4. DATE OF DEATH Month December Day 30 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1892
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 3 Days 01 Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boilermaker		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes, give year or dates of service) WW-1		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records, VA Hospital, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, unresolved, left lower lobe 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, general, severe - unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 26, 1932 , to December 30, 1956 , and that death occurred at 12:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Perry Point, Maryland DATE SIGNED 12-31-56			
ACTUAL SIGNATURE W. Oppler M.D.		PHYSICIAN'S NAME (Type) W. OPPLER, Director, Professional Services, VAH., Perry Point, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12-31-56	
22c. NAME OF CEMETERY OR CREMATORY Holy Rosary		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Ozazewski		24a. REC'D BY REGISTRAR 3 1957	
ADDRESS 1930 Eastern Ave. Baltimore, Md.		24b. REGISTRAR'S SIGNATURE John D. ...	

CENTRAL DATE OF DEATH

BUREAU V. S.

JAN 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12348

Reg. Dist. No.

12361

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>				d. STREET ADDRESS <u>112 Church St.</u>			
3. NAME OF DECEASED (Type or print) First <u>HAMEL</u> Middle <u>-</u> Last <u>BOUCHELLE</u>				4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-30-1876</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>19</u> Hours <u>58</u>		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JANITOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>CHARLES THOMAS BOUCHELLE</u>				14. MOTHER'S MAIDEN NAME <u>AMELIA PEARCE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mrs. AMY M. BOUCHELLE</u>				Address <u>112 Church St. Elkton Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR THROMBOSIS</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL VASCULAR SCLEROSIS</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3-4 years</u> <u>6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov 30</u> , 19 <u>58</u> , to <u>Dec 2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 2</u> , 19 <u>58</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Peter Stavrakis</u>				ADDRESS (Street, city or town, state) <u>154 W. MAIN ST. ELKTON, MD.</u>			
PHYSICIAN'S NAME (Type) <u>PETER STAVRAKIS</u>				DATE SIGNED <u>12-2-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>December 5, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tiffin Memorial Home, PA.</u>		22d. LOCATION (City, town, or county) (State) <u>R.D. Elkton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Henry Pappin</u>				ADDRESS <u>259 E. Main St. Elkton Md.</u>		24b. REGISTRAR'S SIGNATURE <u>J.R. Frazer</u>	
24a. REC'D BY REGISTRAR <u>12/4/58</u>				DATE <u>12/4/58</u>			

CERTIFICATE OF DEATH

1956

RECEIVED
DEC 5 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12382

CERTIFICATE OF DEATH

12349

Reg. Dist. No. 94

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Miriam Rose Boyer</u>				4. DATE OF DEATH Month Day Year <u>December 28 19 56</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>April 25 1914</u>		9. AGE (In years last birthday) <u>42</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coffee Shop</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Herman Boyer</u>				14. MOTHER'S MAIDEN NAME <u>Mrytle Rose</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-01-7508</u>		17. INFORMANT Address <u>Mrs Mrytle R. Boyer North East, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>175X GENERAL CONSUMPTION, CIRCULATORY</u> DUE TO (b) <u>WIDESPREAD CANCER WITH MULTIPLE</u> DUE TO (c) <u>METASTASIS IN INTEST., LIVER, BONES ETC</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>						INTERVAL BETWEEN ONSET AND DEATH <u>appr. 2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 15</u> , 19 <u>56</u> , to <u>Dec. 28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>December 28 19 56</u> , and that death occurred at <u>10:25 p. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>North East</u> DATE SIGNED <u>12-28-56</u>							
ACTUAL SIGNATURE <u>Otto Vogel</u> M.D.				DATE <u>Jan 2-57</u>			
PHYSICIAN'S NAME (Type) <u>OTTO VOGEL M.D.</u>				24b. REGISTRAR'S SIGNATURE <u>Sarah E. Pothornel</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>North East Cecil Co., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph A. Hunt</u> ADDRESS <u>North East, Maryland</u>				24a. REC'D BY REGISTRAR <u>Jan 2-57</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 4 1957

RECEIVED

12365

12365

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12350

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cecil</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cecil</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN W. BRAXTON</u>		4. DATE OF DEATH Month Day Year <u>Dec. 1 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 20 1883</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Delaware Braxton</u>		14. MOTHER'S MAIDEN NAME <u>Esther Barnett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-09-4818</u>	
17. INFORMANT <u>John Braxton</u>		Address <u>Cecil Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> 19 <u>56</u> , to <u>Dec 1</u> 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 1</u> 19 <u>56</u> , and that death occurred at <u>2:30</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Wallace Obenshain</u> M.D. <u>Cecil Md</u> <u>2 Dec 56</u> PHYSICIAN'S NAME (Type)			
22a. BURIAL CREMATION REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. GENERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
DATE		DATE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reviewed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

REC 5



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12383

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NORTHEAST	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First THOMAS Middle E Last BROWN		4. DATE OF DEATH Month December Day 31 Year 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 18, 1907
9. AGE (In years, last birthday) 49 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Shoe	
11. BIRTHPLACE (State or foreign country) Pueblo, Colorado		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM D. BROWN		14. MOTHER'S MAIDEN NAME FLORENCE LOCKIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW-II		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records, VA Hospital, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 11/3/56 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, squamous cell type, floor of mouth, left DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4-5 days unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 9, 1956 to December 31, 1956 and that death occurred at 1:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Perry Point, Maryland DATE SIGNED 12-31-56 ACTUAL SIGNATURE W. Oppler M.D. PHYSICIAN'S NAME (Type) W. OPPLER, M.D., Director, Professional Services, VAH., Perry Point, Maryland			
22a. BURIAL, CREMATION, REMOVAL REMOVAL		22b. DATE THEREOF 12-31-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Harold H. Jones, Md.		24a. REC'D BY REGISTRAR DATE 1-4-57	
24b. REGISTRAR'S SIGNATURE James E. Daugherty			

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BUREAU V. 3

12384

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived II institution: Residence before admission) a. STATE PENN. b. COUNTY CHESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY POINT				c. LENGTH OF STAY IN 1b 6 Mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS ROUTE # 2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ANDREW Middle BUCHANAN Last BUCHANAN				4. DATE OF DEATH Month DECEMBER Day 9 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 1, 1878	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY MILK PLANT		11. BIRTHPLACE (State or foreign country) NOTTINGHAM, PA.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME ANDREW BUCHANAN				14. MOTHER'S MAIDEN NAME KATHARINE ST CLAIR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216-05-8938			
17. INFORMANT WILMER BUCHANAN PERRYPOINT, MD				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Stomach DUE TO Carcinomatous Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Carcinomatous DUE TO Carcinoma (c) Carcinoma							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 1, 1956 to Dec 9, 1956 , that I last saw the deceased alive on Dec 9, 1956 , and that death occurred at 3 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Charles J. Fily M.D. 12/14/56							
ACTUAL SIGNATURE Charles J. Fily				PHYSICIAN'S NAME (Type) Charles J. Fily			
22a. BURIAL, CREMATON, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/12/56		22c. NAME OF CEMETERY OR CREMATORY FREEMONT		22d. LOCATION (City, town, or county) (State) NOTTINGHAM PA.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph M Reed				ADDRESS Ring Sun, Md		24a. REC'D BY REGISTRAR DATE 12/10/56	
24b. REGISTRAR'S SIGNATURE James E. Dougherty							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12385 12385 CERTIFICATE OF DEATH

12353

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point,				c. LENGTH OF STAY IN 1b 29yrs2mos26days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARLINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2922 N. Glebe Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle ROLAND Last BUCKLEY				4. DATE OF DEATH Month December Day 24 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1890		9. AGE (In years last birthday) 66 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Gainsville, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME William A. Buckley				14. MOTHER'S MAIDEN NAME Mabelle Simpson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) WW-I		16. SOCIAL SECURITY NO None		17. INFORMANT Hospital Records, VAH., Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Myocardial fibrosis left ventricular wall DUE TO Coronary sclerosis, severe (c) arteriosclerosis generalized, severe						Unknown Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 28, 1927 , to December 24, 1956 and that death occurred at 2:20A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Joseph C. Grasberger M.D. VAH., Perry Point, Maryland							
PHYSICIAN'S NAME (Type) J. C. GRASBERGER, M.D., Actg. Director Professional services, Perry Point, Md.							
22a. BURIAL, CREMATION, REMOVAL REMOVAL		22b. DATE THEREOF 12-27-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Emmanuel J. DeGrace				ADDRESS Havre DeGrace, Md.		24a. REC'D BY REGISTRAR DATE 12-24-56	
				24b. REGISTRAR'S SIGNATURE Emmanuel J. DeGrace			

BUREAU V. S.

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12386

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Conowingo Rural</u>				c. LENGTH OF STAY IN 1b <u>4 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Elaine</u> Last <u>Burton</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>8</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 30, 1956</u>	
9. AGE (In years last birthday) yrs <u>4</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>9</u> Hours <u></u> Min. <u></u>		11. BIRTHPLACE (State or foreign country) <u>Elkton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>			
13. FATHER'S NAME <u>John Burton</u>				14. MOTHER'S MAIDEN NAME <u>Marie Willen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.		17. INFORMANT <u>John F. Burton</u> Address <u>Conowingo, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral Broncho Pneumonia</u> 48 hours <u>471X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12-6-56</u> 19 <u>12</u> to <u>12-8-56</u> 19 <u></u> that I last saw the deceased alive on <u>12-6-56</u> 19 <u></u> and that death occurred at <u>5</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. C. Dodson</u> M.D.				ADDRESS (Street, city or town, state) <u>Rising Sun, Cecil Co. Md.</u> DATE SIGNED <u>12-8-56</u>			
PHYSICIAN'S NAME (Type) <u>R. C. Dodson, M.D.</u>				<u>Rising Sun, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 10, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Near Fort Deposit, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl Tyson</u> ADDRESS <u>Rising Sun, Md.</u>				24a. REC'D BY REGISTRAR <u>12/10/56</u>		24b. REGISTRAR'S SIGNATURE <u>L. M. Northington</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please replace carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

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RECEIVED

12366

CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b 9 hours d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ABEL Middle C Last CAMERON			4. DATE OF DEATH Month December Day 14 Year 1956				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1875	9. AGE (In years last birthday) 81 yrs	IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Manufacture		10b. KIND OF BUSINESS OR INDUSTRY Fire Brick		11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME James Nelson Cameron			12. CITIZEN OF WHAT COUNTRY? U.S.A				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 219-05-6870				
17. INFORMANT J. Nelson Cameron			Address North East, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO ACUTE HEART INSUFFICIENCY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SILICOSIS + INVETERATED INACTIVE LUNG-TUBERCULOSIS					INTERVAL BETWEEN ONSET AND DEATH 10 hours 10 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from NOV. 1, 1956 to Dec 14, 1956 , that I last saw the deceased alive on Dec 13, 56, 19 , and that death occurred at 6 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) NORTH EAST DATE SIGNED 12-15-56 ACTUAL SIGNATURE Otto Vogel M.D. PHYSICIAN'S NAME (Type) OTTO VOGEL, MD NORTH EAST							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-17-1956	22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) North East, Cecil Co, Md		
23. FUNERAL DIRECTOR'S SIGNATURE Joseph T. Grant			ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE Dec 17		
			24b. REGISTRAR'S SIGNATURE IR Frazer				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1956

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12387

CERTIFICATE OF DEATH

12356

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Locust Pt.				d STREET ADDRESS Locust Pt. RFD No. 2			
3. NAME OF DECEASED (Type or print) First Middle Last M. ROSS CAUSEY				4. DATE OF DEATH Month Day Year Dec. 5, 1956			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1903	9. AGE (In years last birthday) yrs. 53	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed				10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Lewis M. Causey				14. MOTHER'S MAIDEN NAME Minnie H. -- (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO 215-05-5692		17. INFORMANT Address Mrs. Ruby T. Causey-RED #2 Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant brain tumor (Glinna -st) 193x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH About 8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August 9, 1956 , to Death 5, 1956 , that I last saw the deceased alive on December 5, 1956 , and that death occurred at 3:15 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews Jr.				ADDRESS (Street, city or town, state) 233 E. Main St., Elkton, Md.		DATE SIGNED 12/5/56	
PHYSICIAN'S NAME (Type) S. RALPH ANDREWS JR., M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/8/56		22c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23 FUNERAL DIRECTOR'S SIGNATURE Edm. J. Vickener & Sons				ADDRESS Balto 17, Md.		24a. REC'D BY REGISTRAR Dec. 10 1956	
				24b. REGISTRAR'S SIGNATURE L. K. Fugate			

RECEIVED

DEC 11 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12388

CERTIFICATE OF DEATH

12357

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>				c. LENGTH OF STAY IN 1b <u>14yrs.8mo.10days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>1014 Hewitt Way</u>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>C.</u> Last <u>DOTSON</u>				4. DATE OF DEATH Month <u>December</u> Day <u>4</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-8-95</u>		9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Ulysses G. Dotson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Alice Wright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/> <u>I</u> <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Hospital Records, VAN, Perry Point, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculosis, pulmonary, far advanced, right upper lobe</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, general, moderate</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 24, 1942</u> , to <u>December 4, 1956</u> , that I was the attending physician, and that death occurred at <u>8:50a. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Apple</u>				ADDRESS (Street, city or town, state) <u>V.A. Hospital, Perry Point, Md.</u>			
PHYSICIAN'S NAME (Type) <u>W. OFFLER</u>				DATE SIGNED <u>12-6-56</u>			
22a. BURIAL, CREMATION, REMOVAL <u>Removal</u>		22b. DATE THEREOF <u>12-6-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pennington & Son, Havre de Grace, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>12-9-56</u>		24b. REGISTRAR'S SIGNATURE <u>James E. Langley</u>	

BUREAU A. S.

DEC. 11 1956

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12358

12367

CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY <u> Cecil </u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u> Md. </u> b. COUNTY <u> Cecil </u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u> Elkton </u>				c. LENGTH OF STAY IN 1b <u> — </u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u> 945 W. High Street </u>			
3. NAME OF DECEASED (Type or print) <u> Mabel Sophia Ehlers </u>				4. DATE OF DEATH <u> Dec. 20th </u> 19 <u> 56 </u>			
5. SEX <u> Female </u>		6. COLOR OR RACE <u> White </u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u> Nov. 1st 1870 </u> 86 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> none </u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u> Elkton - Md. </u>		12. CITIZEN OF WHAT COUNTRY? <u> U.S.A. </u>	
13. FATHER'S NAME <u> Alexander M. Ehlers </u>				14. MOTHER'S MARDEN NAME <u> Sophia Letton </u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or other) <u> no </u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u> Marjorie Sarkin - Elkton - Md daughter </u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u> Chronic myocarditis </u> DUE TO <u> General arteriosclerosis </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> — </u> DUE TO (c) <u> — </u>				INTERVAL BETWEEN ONSET AND DEATH <u> about 5 yrs </u> <u> unknown </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u> 56 </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u> July 20 </u> , 19 <u> 56 </u> , to <u> Dec 20 </u> , 19 <u> 56 </u> , that I last saw the deceased alive on <u> Dec 19 </u> , 19 <u> 56 </u> , and that death occurred at <u> 2.00 PM </u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u> F. H. McLaughlin </u>				ADDRESS (Street, city or town, state) <u> 113 Bridge Street, Elkton - Maryland </u>			
PHYSICIAN'S NAME (Type) <u> F. H. McLaughlin </u>				DATE SIGNED <u> Dec 27 </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> Burial </u>		22b. DATE THEREOF <u> 12-23-1956 </u>		22c. NAME OF CEMETERY OR CREMATORY <u> Elkton Cemetery </u>		22d. LOCATION (City, town, or county) (State) <u> Elkton, Md. </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> W. Henry Offin </u> ADDRESS <u> 259 E. Main St. Elkton, Md. </u>				24a. REC'D BY REGISTRAR <u> Dec 27 </u>		24b. REGISTRAR'S SIGNATURE <u> FR Frager </u>	

BUREAU V. S.

DEC

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

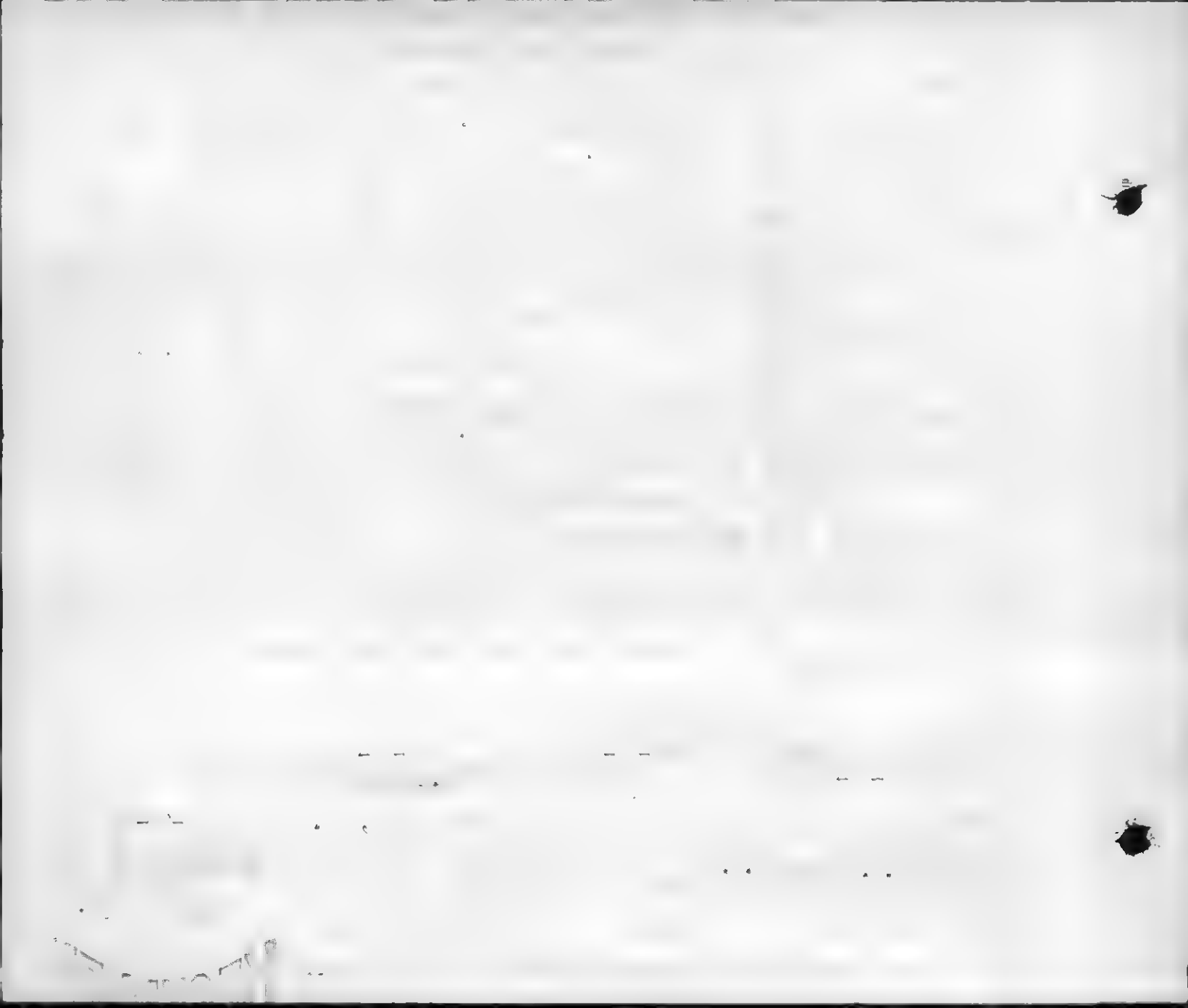
12389

CERTIFICATE OF DEATH

12359

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun Rural</u>				c. LENGTH OF STAY IN 1b <u>37 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>Nicklas</u> Last <u>Hansen</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>39</u> Year <u>56</u> 19			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1873</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>		11. BIRTHPLACE (State or foreign country) <u>Shesvieg Holstein Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Nicklas Hansen</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Claussen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>one</u>		17. INFORMANT <u>Harry .Hansen</u> Address <u>North East, Md. Box 44</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>1221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Rising Sun, Md.</u>		(County) <u>Md.</u>		(State) <u>Md.</u>
21. I certify that I attended the deceased from <u>2-18-56</u> , 19 <u>56</u> , to <u>12-28-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-28-56</u> , 19 <u>56</u> , and that death occurred at <u>11:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rising Sun, Md.</u> DATE SIGNED <u>12-29-56</u>							
ACTUAL SIGNATURE <u>R. C. Dodson</u> M.D. <u>Rising Sun, Md.</u> <u>12-29-56</u>							
PHYSICIAN'S NAME (Type) <u>R. C. Dodson M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 31, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Near Fort Deposit Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson</u>				ADDRESS <u>Rising Sun, Md.</u>		24. REC'D BY REGISTRAR <u>Dec 31-56</u>	
				25. REGISTRAR'S SIGNATURE <u>L. M. Worthington</u>			



12368

CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colora Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Jennie Heyberger				4. DATE OF DEATH Month Day Year December 12 1956			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2 1863	9. AGE (In years last birthday) 93 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housework		10b. KIND OF BUSINESS OR INDUSTRY General Housework		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph Heyberger				14. MOTHER'S MAIDEN NAME No information			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Maud Ewing		Address Colora, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinome of the Bladder 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 10 1956, to 12-11-56, 1956, that I last saw the deceased alive on 12-11, 1956, and that death occurred at 5 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Rising Sun, Md. 12-14-56							
ACTUAL SIGNATURE A. L. Dodson M.D.				DATE SIGNED 12-14-56			
PHYSICIAN'S NAME (Type) R. C. Dodson, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 16, 1956		22c. NAME OF CEMETERY OR CREMATORY Brookview Cem.		22d. LOCATION (City, town, or county) (State) Rising Sun Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Earl T. Young				ADDRESS Rising Sun, Md.		24a. REC'D BY REGISTRAR DATE Dec 17	
				24b. REGISTRAR'S SIGNATURE H. T. Trager			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cover papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

TO 1906

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12390

CERTIFICATE OF DEATH

12361

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE D.C. b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 1 mo. 28days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington,		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			d. STREET ADDRESS 29-46th St., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle James Last Hudson			4. DATE OF DEATH Month December Day 21, Year 1956		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-6-19		9. AGE (In years last birthday) 37 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist helper		10b. KIND OF BUSINESS OR INDUSTRY Unk.	11. BIRTHPLACE (State or foreign country) Macon, Ga.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Hudson			14. MOTHER'S MAIDEN NAME Hattie Green		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes.		16. SOCIAL SECURITY NO WH11 261 14 5561	17. INFORMANT VAH, Records, Perry Point, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia, bilateral, unresolved DUE TO (b) Pyelonephritis, bilateral, severe DUE TO Prostatic hypertrophy (c) Urethral stricture					INTERVAL BETWEEN ONSET AND DEATH 4 - 5 days Unknown Unknown Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 23, 1956 , to December 21, 1956 , and that death occurred at 3:30 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED E. S. ELLS, M.D. V. A. Hospital, Perry Point, Md. 12/23/56					
ACTUAL SIGNATURE E. S. ELLS					
PHYSICIAN'S NAME (Type) E. S. ELLS, M.D., Acting, Director, Professional Services, VAH., Perry Point, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12-24-56	22c. NAME OF CEMETERY OR CREMATORY DUVAL CEMETERY		22d. LOCATION (City, town, or county) (State) Jacksonville, Florida
23. FUNERAL DIRECTOR'S SIGNATURE PENNINGTON & SON, Harry de Grace, Maryland.			24a. REC'D BY REGISTRAR DATE 12-23-56		
			24b. REGISTRAR'S SIGNATURE Frederic E. Langford		

BUREAU V. S.

DEC 1906

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TO REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12362

CERTIFICATE OF DEATH

Reg. Dist. No. 96

12391

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY POINT			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			e. STREET ADDRESS 1647 Shadyside Road		
3. NAME OF DECEASED (Type or print) First GEORGE Middle THOMAS Last KIRK			4. DATE OF DEATH Month December Day 17 Year 19 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 17, 1893		9. AGE (In years last birthday) 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10b. KIND OF BUSINESS OR INDUSTRY City of Balto.	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME WILLIAM H. KIRK			14. MOTHER'S MAIDEN NAME ELZRINA COPELAND		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I	17. INFORMANT Hospital Records, VAH., Perry Point, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral thrombosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, general - unknown					INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 6 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from August 13, 1951 , to December 17, 1956 , and that death occurred at 8:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 12-18-56					
ACTUAL SIGNATURE W. Oppler		M.D. V.A. Hospital, Perry Point, Md.			
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 12-18-56	22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE WM. J. TICKNER & SONS, North & Penna. Ave; Balto., Md.		ADDRESS BALTO., MD.		24a. REC'D BY REGISTRAR 12/18/56	24b. REGISTRAR'S SIGNATURE

RECEIVED
JUL 1 1964
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12363

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY Cecil				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 14 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		d. STREET ADDRESS 426 North St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital D.O.A.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Limnios Last				4. DATE OF DEATH Month 12 Day 5 Year 19 56			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 6, 1891	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe maker		10b. KIND OF BUSINESS OR INDUSTRY Repairing shoes		11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Angeles Limnios				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Angeles Limnios, 426 North St. Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson				DATE SIGNED 12-5-56			
EXAMINER'S NAME (Type) R. C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 8, 1956		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks				24a. REC'D BY REGISTRAR 12/8/56		24b. REGISTRAR'S SIGNATURE FR Frazer	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEC 11 1956

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12364

12370

CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY <u>Beecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived or institution; residence before admission) o. STATE <u>Elkton Md</u> COUNTY <u>Beecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>	c. LENGTH OF STAY IN 1b <u>15 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Union</u>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Howard</u> First <u>Lodge</u> Middle <u>Lodge</u> Last		4. DATE OF DEATH <u>Dec</u> - <u>17th</u> Day Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 15 1880</u> 9. AGE (In years last birthday) <u>76</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Richard H. Lodge</u>		14. MOTHER'S MAIDEN NAME <u>Jane Hall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Ida Lodge - wife</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>General Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 21</u> , 19 <u>56</u> to <u>Dec 17th</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 22</u> , 19 <u>56</u> , and that death occurred at <u>11:05</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>V. H. McNeight</u> M.D.		ADDRESS (Street, city or town, state) <u>Elkton - Maryland</u> DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-21-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Memo. Pk.</u>	22d. LOCATION (City, town, or county) (State) <u>R. D. Elkton Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Henry Biffin</u> ADDRESS <u>259 E. Main St. Elkton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Dec 21</u>	24b. REGISTRAR'S SIGNATURE <u>JR Frazier</u>

BUREAU U. S.

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12371

CERTIFICATE OF DEATH

Reg. Dist. No.

12365

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Berkley County</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Martinsburg, W. Va.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				d. STREET ADDRESS <u>223 N. College Street</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Virginia B. Owens</u>				4. DATE OF DEATH Month Day Year <u>December 3 1956</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 26, 1916</u>	
9. AGE (In years lost birthday) <u>40</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Martinsburg, West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Preston Shade</u>			
14. MOTHER'S MAIDEN NAME <u>Hattie Stotler</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>236-16-3841</u>				17. INFORMANT <u>Theo Shade-brother</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetic coma -3 days. Uremia-unknown time.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetic coma -3 days. Uremia-unknown time.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Elkton, Md.</u>				20g. (County) <u>Cecil</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>Dec 1</u> , 1956, to <u>Dec 3</u> , 1956, that I last saw the deceased alive on <u>Dec 3</u> , 1956, and that death occurred at <u>4:30 p. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wallace Obenshain</u> M.D.				DATE SIGNED <u>3 Dec 56</u>			
PHYSICIAN'S NAME (Type) <u>Wallace Obenshain M.D.</u>				ADDRESS (Street, city or town, state) <u>Cecilton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 7, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Martinsburg, West Va.</u>		22d. LOCATION (City, town, or county) (State) <u>Martinsburg, West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>				ADDRESS <u>103 Stockton Street Elkton, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>12/4/56</u>	
24b. REGISTRAR'S SIGNATURE <u>IR Frazer</u>							

RECEIVED
DEC 1
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Film 209 1-8-57 ams

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 11 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		d. STREET ADDRESS 324 N. Union Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle R. Last PAHR		4. DATE OF DEATH Month December Day 10 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-12-88
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipper		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Pahr		14. MOTHER'S MAIDEN NAME Dorothea A. Frain	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 219-104-023	
17. INFORMANT V.A. Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia and (recurrent) (1 year) 102.0 DUE TO Lacerations of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral hydronephrosis DUE TO (c) Fracture of hip injury (fall from stairs)		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 11-29-56 p. m. 11		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Havre de Grace, Md. (County) (State)	
21. I certify that I attended the deceased from November 29, 19 56, to December 10, 19 56, that I last saw the deceased alive on December 10, 19 56, and that death occurred at 10:55 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 12-10-56	
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-13-56	
22c. NAME OF CEMETERY OR CREMATORY Angel Hill		22d. LOCATION (City, town, or county) Havre de Grace, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE R. MADISON MITCHELL		ADDRESS Havre de Grace, Md.	
24a. REC'D BY REGISTRAR DATE 12-12-56		24b. REGISTRAR'S SIGNATURE Irene E. Dougherty	

BUREAU N. 1

DEC 17 1946

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12372

CERTIFICATE OF DEATH

123672
Dist. No.

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hospital, Elkton		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hosp				d. STREET ADDRESS 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Edward Middle Leo Last Paerento		4. DATE OF DEATH Month Dec Day 23 Year 1956				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 20, 1956	9. AGE (In years last birthday) yrs. 3	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Bernard Paerento		14. MOTHER'S MAIDEN NAME Alice Milam				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Bernard Paerento Address R. 3, N. # 3		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adrenal failure 3.5 DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)		(County)		(State)		
21. I certify that I attended the deceased from _____, 19____, to 23 Dec, 1956, that I last saw the deceased alive on 23 Dec, 1956, and that death occurred at _____ M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Chifton R. Brooks M.D. Union Hosp of Cecil Co 24 Dec 56						
ACTUAL SIGNATURE NAME (Type) James Chason						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Dec 27, 1956		22c. NAME OF CEMETERY OR CREMATORY Blake Cemetery		
22d. LOCATION (City, town, or county)		(State) Blake, Md				
23. FUNERAL DIRECTOR'S SIGNATURE Donald M. Lee		ADDRESS ELKTON, Md.		24a. REC'D BY REGISTRAR DATE Dec 27		
24b. REGISTRAR'S SIGNATURE J. P. Fraser						

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BUREAU V. S.

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RECEIVED

12373 CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS R. F. D. # 1	
3. NAME OF DECEASED (Type or print) Dorothy Ann Poore		4. DATE OF DEATH Dec. 22 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 5, 1906
9. AGE (in years last birthday) yrs 3		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Elkton		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Winfield Poore		14. MOTHER'S MAIDEN NAME Shirley Chadwick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT R. F. # 1 Winfield Poore		Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Dec. 20, 1956	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 21, 1956, to Dec. 22, 1956, that I last saw the deceased alive on Dec. 22, 1956, and that death occurred at 10:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Winfield H. Spearman M.D.		ADDRESS (Street, city or town, state) Elkton, Md. DATE SIGNED Dec. 23, 1956	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-24-1956	22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery	22d. LOCATION (City, town, or county) (State) Elkton Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Spearman		24a. REC'D BY REGISTRAR DATE Dec 27	24b. REGISTRAR'S SIGNATURE J. R. Frazer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 28 1956

RECEIVED

12393

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Middle Last Ella India Reynolds		4. DATE OF DEATH Month Day Year Dec. 18 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1869
9. AGE (In years last birthday) 87 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Rising Sun, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Pierce		14. MOTHER'S MAIDEN NAME Sara Pierce	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 11-410	
17. INFORMANT Mrs. Mary Lawrence		Address Rising Sun,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X Uremia DUE TO (b) Renal arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 wks 3 mos
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1954 to 12/18 1956 that I last saw the deceased alive on 12/18 1956, and that death occurred at 9 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rising Sun, Md. DATE SIGNED 12/19/56 ACTUAL SIGNATURE Ned Taylor M.D. PHYSICIAN'S NAME (Type) Ned Taylor			
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		22b. DATE THEREOF Dec 22, 1956	
22c. NAME OF CEMETERY OR CREMATORY Brookview Cem,		22d. LOCATION (City, town, or county) (State) Coloma, Ind.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Earl Tyson		ADDRESS Rising Sun, Md.	
24a. REC'D BY REGISTRAR DATE Dec 14/56		24b. REGISTRAR'S SIGNATURE L. M. Northington	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUN 21 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12370
Reg. Dist. No. 76

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mass. b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boston	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Parlor Car on train 171 P.R.R.			d. STREET ADDRESS 514 Masschutis Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) William First Middle Last 0 Sawyers			4. DATE OF DEATH Month 12 Day 11 Year 19 56		
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 8-7-1906			9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Parlor Car Attend		10b. KIND OF BUSINESS OR INDUSTRY Pullman Co.		11. BIRTHPLACE (State or foreign country) Tenn.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Wm. I Sawyers		
14. MOTHER'S MAIDEN NAME Sallie Owens			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.			17. INFORMANT Laura Anderson Address 315 Neill Ave.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage from Peptic Ulcer DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE R. C. Dodson			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) R.C. Dodson			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 12-12-56		
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12-13-56		22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	
22d. LOCATION (City, town, or county) Nashville, Tenn.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE See a. Patterson & Son, Perryville, Md.			ADDRESS		
24a. REC'D BY REGISTRAR DATE 12-13-56		24b. REGISTRAR'S SIGNATURE James E. Laughlin			

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

12371

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY Cecil CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Elkton HOSPITAL OR INSTITUTION OR STREET ADDRESS 220 E. Main		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Cecil CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Elkton STREET ADDRESS (If rural give location) 220 E. Main	
3. NAME OF DECEASED (Type or Print) (First) Delancey (Middle) Delancy (Last) Scott		4. DATE OF DEATH (Month) 12 (Day) 30 (Year) 19 56	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 2-3-1887
9. AGE last birthday 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Town Treas.		10b. KIND OF BUSINESS OR INDUSTRY Town Official	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Scott		14. MOTHER'S MAIDEN NAME Rachael Wilson Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. 218-32-9260	
17. INFORMANT & ADDRESS Mrs. Dolly Scott, Elkton, Md.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Uremia			
ANTECEDENT CAUSE(S) DUE TO (B) Cancer of prostate and colon and			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) right kidney			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11-1-56, 19...p., to 12-30-56, 19...p., that I last saw the deceased alive on 12-30-56, 19...p., and that death occurred at 4:03 A.M. from the causes and on the date stated above.			
SIGNATURE Alex Doelson		ADDRESS (Street, city, town, state) Rising Sun Md.	
DATE Jan 1, 1957		DATE SIGNED 12-31-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1/1/57	
24. REC'D BY REGISTRAR H. H. Frazer		NAME OF CEMETERY OR CREMATORY Elkton Cemetery	
25. FUNERAL DIRECTOR'S SIGNATURE H. H. Frazer		LOCATION (City, town, or county) Elkton	
26. ADDRESS H. H. Frazer			

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12395

CERTIFICATE OF DEATH

12372

Reg. Dist. No. 92

James P. Scott 2/27/57

1. PLACE OF DEATH COUNTY <i>Cecil</i> CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Chadds</i> TOWN		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Wecil</i> CITY (If outside corporate limits, write RURAL and give nearest town) <i>Chadds</i> TOWN	
3. NAME OF DECEASED (Type or Print) <i>J. Bayard Scott</i> (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <i>Dec 28 1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Married</i>	8. DATE OF BIRTH <i>1905-10-10</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Master</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Cecil County</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>J. Polk Scott</i>		14. MOTHER'S MAIDEN NAME <i>Harry Ellen Chapman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <i>James P. Scott + son</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 7230 IMMEDIATE CAUSE (A) <i>Malignant tumor of osteoarthritis about 35 yrs</i> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <i>General arteriosclerosis</i> (C) <i>unknown</i>		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <i>M.</i> <input type="checkbox"/> <i>Not while at work</i> <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Dec 27</i> , 1956, to <i>Dec 28</i> , 1956, that I last saw the deceased alive on <i>Dec 27</i> , 1956, and that death occurred at <i>3:00 PM</i> , from the causes and on the date stated above. SIGNATURE <i>V. H. McLaughlin</i> M.D. ADDRESS <i>Elkton - Maryland</i> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>12-31-1956</i>	NAME OF CEMETERY OR CREMATORY <i>Cherry Hill Cemetery</i>	LOCATION (City, town, or county) (State) <i>Cherry Hill Md</i>
24. REC'D BY REGISTRAR <i>1/3/57</i>	REGISTRAR'S SIGNATURE <i>J. R. Frager</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>W. Henry Pipp</i>	ADDRESS <i>237 E. Main St. Elkton, Md.</i>

W. A. RUTLAND

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12373

12396

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 7 mos. 29 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS 830 Jefferson St., N.W.							
3. NAME OF DECEASED (Type or print) John		First Albert		Middle Smith		Last	
4. DATE OF DEATH Month December Day 22 Year 19 56							
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-30-90	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Govt. Clerk		10b. KIND OF BUSINESS OR INDUSTRY Federal		11. BIRTHPLACE (State or foreign country) South Dakota		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry W. Smith, Jr.				14. MOTHER'S MAIDEN NAME Ada Wadsworth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW1		16. SOCIAL SECURITY NO 579 28 7014		17. INFORMANT VAH, Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia, bilateral, unresolved 150.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Chronic brain disease manifested by cysts and areas of necrosis. DUE TO (c) Arteriosclerosis, generalized, severe.						INTERVAL BETWEEN ONSET AND DEATH 4-5 days Unknown Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 23, 19 56 to December 22, 19 56 and that death occurred at 2:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE E. S. Ellis				ADDRESS (Street, city or town, state) M.D. V. A. Hospital, Perry Point, Md. DATE SIGNED 12/23/56			
PHYSICIAN'S NAME (Type) E. S. ELLIS, Acting Director, Professional Services, VAH, Perry Point, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12-23-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. HINES COMPANY, Washington, D. C.				24a. REC'D BY REGISTRAR DATE 12-23-56		24b. REGISTRAR'S SIGNATURE James E. Laugherty	

BUREAU V. S.

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RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, and 3 to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12374

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS 311 Hollingworth Manor	
3. NAME OF DECEASED (Type or print) First Middle Last Carl Lee Speck		4. DATE OF DEATH Month 12 Day 11 Year 19 56	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-13-1925
9. AGE (In years last birthday) 31 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant V.A. Hosp.		10b. KIND OF BUSINESS OR INDUSTRY Attendant	
11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Luther Boyd Speck		14. MOTHER'S MAIDEN NAME Mary Lou England	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes W.W.2		16. SOCIAL SECURITY NO. 215-32-9428	
17. INFORMANT Mildred Speck. 311 Hollingworth, Manor		Address Elkton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound fracture Base of Skull also DUE TO Conditions, if any, which gave rise to immediate cause (b) right frontal bone through right eye (c) Laceration of left side of neck. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.) Car ran under a truck loaded with steel	
20c. TIME OF INJURY Month, Day, Year 1.55 p.m. 12-11-56	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40	20f. (City or town) North East Cecil (County) Md. (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 13, 1956	
22c. NAME OF CEMETERY OR CREMATORY Principio Cemetery		22d. LOCATION (City, town, or county) Cecil Co. Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks, Elkton, Md.		24a. REC'D BY REGISTRAR DATE Dec 15	
		24b. REGISTRAR'S SIGNATURE J.R. Frazer	

BUREAU V. S.

DEC 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12376

CERTIFICATE OF DEATH

12375
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EIKTON</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EIKTON</u>	
		d. STREET ADDRESS <u>301 Hollingsworth Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>C.</u> Last <u>Taylor</u>		f. DATE OF DEATH Month <u>Dec.</u> Day <u>11</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1906</u>
9. AGE (In years last birthday) <u>50 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electr</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tidewater Inc</u>	
11. BIRTHPLACE (State or foreign country) <u>Paint Creek, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SIDNEY TAYLOR</u>		14. MOTHER'S MAIDEN NAME <u>EDNA INGRAM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>236-01-0113</u>	
17. INFORMANT <u>Mrs. Dorothy Crooks</u>		Address <u>EIKTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>IX</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 9</u> , 1956, to <u>Nov. 11</u> , 1956, that I last saw the deceased alive on <u>Nov. 11</u> , 1956, and that death occurred at <u>3:30</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Milford H. Sprecher, M.D.</u>		ADDRESS (Street, city or town; state) <u>Elkton, Md</u>	
PHYSICIAN'S NAME (Type) <u>Milford H. Sprecher</u>		DATE SIGNED <u>Nov. 11, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-16-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SUNSET MEMORIAL</u>	22d. LOCATION (City, town, or county) (State) <u>Charleston, W. Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		ADDRESS <u>Elkton, Md</u>	
24a. REC'D BY REGISTRAR <u>Dec 15</u>		24b. REGISTRAR'S SIGNATURE <u>JR. Fraser</u>	

BUREAU V. S.

DEC 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12376

Reg. Dist. No. 93

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East, Rural</u>			
c. LENGTH OF STAY IN TB <u>11 yrs</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF <u>Elizabeth</u> First <u>Blanche</u> Middle <u>Taylor</u> Last				4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-26-1908</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>27</u> Hours <u>19</u> Min. <u>56</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House keeping</u>	
11. BIRTHPLACE (State or foreign country) <u>Russell Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Monk</u>		14. MOTHER'S MAIDEN NAME <u>Ethel Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Charles Monk, Rising Sun, Md.</u>		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Nephritis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arterio sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. C. Dodson</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R. C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-27-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-30-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>		22d. LOCATION (City, town, or county) <u>Port Deposit, Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson</u>				ADDRESS <u>Rising Sun, Md.</u>		24a. REC'D BY REGISTRAR <u>Dec 28-56</u> 24b. REGISTRAR'S SIGNATURE <u>L. M. Worthington</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

NOV 21 1956

DEC 31 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12377

CERTIFICATE OF DEATH

12377

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 513 North Street			
3. NAME OF DECEASED (Type or print) William First Middle Last Vinsinger				4. DATE OF DEATH Month December Day 16 Year 1956			
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 8, 1972		9. AGE (In years last birthday) 78 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Clerk Court house		11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Vinsinger				14. MOTHER'S MAIDEN NAME Cordelia Strickland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address 513 North St. Mrs. Carrie W. Vinsinger, Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Cerebral hemorrhage with hemiplegia (b) Hypertensive arteriosclerotic cardiovascular disease (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 5 years Unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I attended the deceased from Aug 1, 1954 to Dec 16, 1956, that I last saw the deceased alive on Dec 15, 1956, and that death occurred at 4:50 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews Jr. M.D.				ADDRESS (Street, city or town, state) 233 E. Main St. Elkton, Md.			
PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR.				DATE SIGNED 12/17/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 16, 1956		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Pappin ADDRESS 259 E. Main St. Elkton, Md.				24a. REC'D BY REGISTRAR DATE Dec 21		24b. REGISTRAR'S SIGNATURE H. Trager	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 13 1930

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12378

12398

CERTIFICATE OF DEATH

Reg. Dist. No.

96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 1yr. 9mos. 9days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2808 - 12th Street, N.E.		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ABNER Middle D. Last WHITE		4. DATE OF DEATH Month December Day 24 Year 56					
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 21, 1887		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ABNER WHITE				14. MOTHER'S MAIDEN NAME MARY C. GANT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-1		17. INFORMANT Hospital Records, VAH., Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis, severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral edema and congestion (Unknown) Arteriosclerosis, generalized, severe, ((Unknown))						INTERVAL BETWEEN ONSET AND DEATH 3-5 days Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 15, 19 55 to December 24 19 56 , and that death occurred at 5:40A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph C. Grasperger		ADDRESS (Street, city or town, state) VAH., Perry Point, Maryland				DATE SIGNED 12-24-56	
PHYSICIAN'S NAME (Type) J. C. GRASBERGER, M. D., Acting Director, Professional Services, VAH., Perry Point, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 12-25-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE REYNOLDS & SON		ADDRESS Havre DeGrace, Md.		24a. REC'D BY REGISTRAR DATE 12-24-56		24b. REGISTRAR'S SIGNATURE James S. Shoghty	

BUREAU V. S.

DEC 21 1900

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12379

12399

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Jecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Id.</u> b. COUNTY <u>Jecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calvert</u>				c. LENGTH OF STAY IN 1b <u>1 Yr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Graybeal Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Marit Thompson</u> First Middle Last				4. DATE OF DEATH <u>Jec.</u> Month Day Year <u>1</u> <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 12 1868</u>	9. AGE (In years last birthday) <u>88</u> yrs	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telegraph Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Penn. R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Clinton Johnson White</u>			
14. MOTHER'S MAIDEN NAME <u>Martha Williams</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT Address <u>Miss Bertha White Chesapeake City</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio sclerosis</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-15</u> , 19 <u>56</u> , to <u>12-1-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-30-56</u> , 19 <u>56</u> , and that death occurred at <u>5</u> A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. C. Dodson</u> M.D.				ADDRESS (Street, city or town, state) <u>Rising Sun, Md.</u>			
DATE SIGNED <u>12-2-56</u>							
PHYSICIAN'S NAME (Type) <u>R. C. Dodson M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/3/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cen.</u>		22d. LOCATION (City, town, or county) (State) <u>Jecil Id.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Walter de B...</u>				ADDRESS <u>Elk...</u>		24a. REC'D BY REGISTRAR DATE <u>12/6/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>L. M. Washington</u>			

PAID

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12380

12378

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 2 days 8 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 304 King Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) C. Raymond 1st: Tworh				4. DATE OF DEATH Dec. 9 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 18, 1891	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CECIL COUNTY SCHOOL BD Engineer				11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME C. Wilmer Witworth				14. MOTHER'S MAIDEN NAME Ella L. Pierson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Elsie Witworth 304 King St. Elkton				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 12/7			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 17, 1956, to Dec. 9, 1956, that I last saw the deceased alive on Dec. 9, 1956, and that death occurred at 10:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Elkton, Md. DATE SIGNED Dec. 9-1956							
ACTUAL SIGNATURE Milford H. Sprecher				Elkton, Maryland			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 12/56		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cherry Hill Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks, 103 Stockton St. Elkton				24a. REC'D BY REGISTRAR DATE Dec 12		24b. REGISTRAR'S SIGNATURE JR. Frazier	

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 13 1958

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12381

Reg. Dist. No. 95

12400

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Cecil Md.</u> b. COUNTY <u>Cecil</u>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calvert</u>			c. LENGTH OF STAY IN 1b <u>all life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calvert</u>								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Georgia</u> Middle <u>S</u> Last <u>Worrilow</u>				4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>19 56</u>								
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-23-1889</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Keeping house</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Mitchell Vandegrift</u>				14. MOTHER'S MAIDEN NAME <u>Phoebe Sapp</u>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Joseph Worrilow, Nottingham, B. D. Pa.</u>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u> </u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .												
ACTUAL SIGNATURE <u>R. C. Dodson</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED				
EXAMINER'S NAME (Type) <u>R. C. Dodson</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12-21-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friends</u>		22d. LOCATION (City, town, or county) <u>Calvert, Cecil Co., Md</u> (State)				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant North East Md</u>						24a. REC'D BY REGISTRAR <u>Dec 20-56</u>		24b. REGISTRAR'S SIGNATURE <u>L. M. Worthington</u>				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 29 1956

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